



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
FAMILY SUPPORT DIVISION

## Provider Attestation of Physician's Order of Medical Necessity

**ATTENTION:** All fields on this document are **required** to be completed.

Patient Name (Print): \_\_\_\_\_ MO HealthNet Number: \_\_\_\_\_  
Provider Name: \_\_\_\_\_  
Certifying Physician Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_  
Care Plan Begin Date: \_\_\_\_\_ Care Plan End Date: \_\_\_\_\_

By signing this form, you are attesting there is a physician's diagnosis of a condition which specifically requires the services provided and billed for this patient. A copy of the physician's order must be made available to the Family Support Division upon request. You attest all services provided and billed are within the scope of the physician's order and are necessary for the treatment of the diagnosed medical condition of this patient.

Anyone who knowingly and willfully makes or causes to be made, a false statement or representation of this statement may be prosecuted under applicable federal or state laws.

**THE FOLLOWING INFORMATION IS REQUIRED TO BE COMPLETED BY THE PROVIDER:**

Name of Provider or Authorized Employee Completing Form (Please print): \_\_\_\_\_  
Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Signature of person completing form: \_\_\_\_\_

## INSTRUCTIONS FOR THE PROVIDER ATTESTATION OF PHYSICIAN'S ORDER OF MEDICAL NECESSITY

**Purpose:** The "Provider Attestation of Physician's Order of Medical Necessity" is used by providers to declare there is a physician's order on record. This attestation verifies provided services or supplies are needed for the diagnosis or treatment of the patient's medical condition and meet accepted standards of medical practice. This form or a Physician's Plan of Care is required prior to allowing medical expenses for services provided in the patient's home to meet spend down; must be updated by the provider when applicable; and must be maintained in the MO HealthNet participant's case record.

**Patient Name:** This field is completed with the name of the patient who has incurred billable medical expenses.

**MO HealthNet Number:** This field is completed with the patient's MO HealthNet number also known as Department Client Number (DCN.) (This is the number on the patient's MO HealthNet card).

**Provider Name:** The provider is to list the name as it appears on their contract with MO HealthNet Division (MHD.) Providers not contracted with MHD are to list their name as it appears on federal income tax documents.

**Certifying Physician Name and Telephone:** Provide the name and telephone number of the physician who has ordered the services provided.

**Care Plan Begin Date:** Enter the date the physician certified that services were needed by this patient.

**Care Plan End Date:** Enter the date the current physician's order expires.

**Name of Provider / Authorized Employee Completing Form:** This field is completed with the typed full name of the provider of the services or authorized employee. The individual completing the Provider Form is attesting to the accuracy of the information and must be able to provide the physician's order, upon request.

**Title:** This field is completed with the title of the provider or authorized employee completing the form.

**Date:** This field is completed with the date the form is completed and signed.

**Address:** This field is completed with the address of the provider or authorized employee completing the form.

**Phone:** This field is completed with the phone number of the provider or authorized employee completing the form.

**Signature:** This field is completed with the signature or signature stamp of the provider or authorized employee completing the form.